

NSAIDs PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for NSAIDs, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – NSAIDs (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested (all ketorolac requests (including Sprix nasal spray) – use "Ketorolac Prior Authorization Form"):

<input type="checkbox"/> Advil	<input type="checkbox"/> diclofenac/misoprostol	<input type="checkbox"/> Flector Patch	<input type="checkbox"/> Mobic tablet	<input type="checkbox"/> Oxaprozin	<input type="checkbox"/> Vimovo
<input type="checkbox"/> Anaprox/Anaprox DS	<input type="checkbox"/> diclofenac topical sol'n	<input type="checkbox"/> Indocin rectal	<input type="checkbox"/> Nalfon	<input type="checkbox"/> Pennsaid pump	<input type="checkbox"/> Vivlodex
<input type="checkbox"/> Arthrotec	<input type="checkbox"/> diflunisal	<input type="checkbox"/> Indocin susp.	<input type="checkbox"/> Naprelan	<input type="checkbox"/> Pennsaid topical sol'n	<input type="checkbox"/> Voltaren XR
<input type="checkbox"/> Celebrex	<input type="checkbox"/> Duexis	<input type="checkbox"/> indomethacin ER	<input type="checkbox"/> Naprosyn	<input type="checkbox"/> Piroxicam	<input type="checkbox"/> Zipsor
<input type="checkbox"/> celecoxib	<input type="checkbox"/> etodolac IR	<input type="checkbox"/> ketoprofen ER	<input type="checkbox"/> Naprosyn EC	<input type="checkbox"/> Ponstel	<input type="checkbox"/> Zorvolex
<input type="checkbox"/> Daypro	<input type="checkbox"/> etodolac ER	<input type="checkbox"/> meclofenamate	<input type="checkbox"/> naproxen CR	<input type="checkbox"/> Tivorbex	<input type="checkbox"/> other: _____
<input type="checkbox"/> Dermacinrx Lexitral	<input type="checkbox"/> Feldene	<input type="checkbox"/> mefenamic acid	<input type="checkbox"/> naproxen sodium Rx	<input type="checkbox"/> tolmetin	
<input type="checkbox"/> diclofenac potassium	<input type="checkbox"/> fenoprofen	<input type="checkbox"/> meloxicam susp.			

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

Celebrex/celecoxib requests:

1. Which of the following apply to the Recipient? Check all that apply and submit supporting documentation for each.

<input type="checkbox"/> is ≥ 65 years of age	<input type="checkbox"/> has clinically-significant GI bleeding	<input type="checkbox"/> has erosive esophagitis
<input type="checkbox"/> has peptic ulcer disease	<input type="checkbox"/> has a coagulation defect	<input type="checkbox"/> has Barrett's Esophagus
<input type="checkbox"/> has NSAID-related ulceration	<input type="checkbox"/> has a history of gastric bypass	<input type="checkbox"/> is currently being treated for hepatitis C

2. Is the Recipient taking any of the following types of medications? Check all that apply and submit Recipient's complete current medication list.

<input type="checkbox"/> anticoagulant	<input type="checkbox"/> antiplatelet agent	<input type="checkbox"/> chronic, systemic corticosteroid	<input type="checkbox"/> any other selective or non-selective NSAID
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Topical NSAIDs requests:

1. Has the Recipient tried and failed, or have a contraindication or intolerance to, any of the preferred oral generic NSAIDs? Check all that apply.

<input type="checkbox"/> diclofenac sodium	<input type="checkbox"/> indomethacin IR	<input type="checkbox"/> meloxicam tablet	<input type="checkbox"/> naproxen Rx (tab, EC tab, susp)
<input type="checkbox"/> flurbiprofen	<input type="checkbox"/> ketoprofen IR	<input type="checkbox"/> Mobic susp.	<input type="checkbox"/> naproxen OTC
<input type="checkbox"/> ibuprofen OTC/Rx	<input type="checkbox"/> ketorolac	<input type="checkbox"/> nabumetone	<input type="checkbox"/> sulindac

<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and treatment outcome</u>
<input type="checkbox"/> No

2. Has the Recipient tried and failed, or have a contraindication or intolerance to, Voltaren Gel?

<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and treatment outcome</u>
<input type="checkbox"/> No

3. Why is the transdermal route of NSAID administration medically necessary for the Recipient? Include explanation in space provided and submit documentation supporting request.

For all other non-preferred NSAID requests:

1. Has the Recipient tried and failed, or have a contraindication or intolerance to, any of the following preferred NSAIDs?

<input type="checkbox"/> diclofenac sodium	<input type="checkbox"/> indomethacin IR	<input type="checkbox"/> meloxicam tab	<input type="checkbox"/> naproxen Rx	<input type="checkbox"/> sulindac
<input type="checkbox"/> flurbiprofen	<input type="checkbox"/> ketoprofen IR	<input type="checkbox"/> Mobic susp.	<input type="checkbox"/> (tab, EC tab, susp)	<input type="checkbox"/> Voltaren Gel
<input type="checkbox"/> ibuprofen OTC/Rx	<input type="checkbox"/> ketorolac	<input type="checkbox"/> nabumetone	<input type="checkbox"/> naproxen OTC	

<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and treatment outcome</u>
<input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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